

OCT 3 2000

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Abbott Park, Illinois 60064-3 53 7

Attention: Thomas F. Willer, Ph.D.  
Associate Director, Regulatory Affairs

Dear Dr. Willer:

Please refer to your supplemental new drug applications dated July 2, 1996, and July 17, 1997, received July 3, 1996, and July 18, 1997, submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act for Tracrium (atracurium besylate) Injection.

Supplement S-021 provides for revisions in the CONTRAINDICATIONS, WARNINGS, DESCRIPTION and PRECAUTIONS sections. The company name and NDC numbers have been revised to reflect the merger of Glaxo Wellcome, Inc

Supplement S-022 provides for revisions on the container label to strengthen a warning and to strengthen an instruction about the dosage.

We have completed our reviews of supplement S-021 and supplement S-022. They are approved effective on the date of this letter.

Revise the container label at the next printing or within 6 months, whichever occurs first, to the following: "100 mg/10mL (10 mg/mL)" changed to "100 mg/10mL (10 mg/mL)"

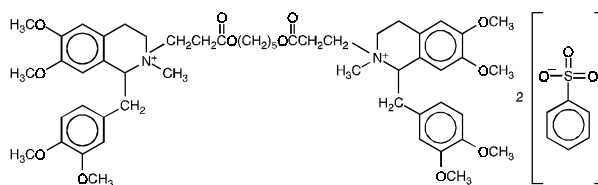
If a letter communicating important information about this drug product (i.e., a "Dear Health Care Practitioner" letter) is issued to physicians and others responsible for patient care, we request that you submit a copy of the letter to this NDA and a copy to the following address:

MED WATCH, HF-2  
FDA  
5600 Fishers Lane  
Rockville, MD 20857

## TRACRIUM® Injection (atracurium besylate)

This drug should be used only by adequately trained individuals familiar with its actions, characteristics, and hazards.

**DESCRIPTION:** TRACRIUM (atracurium besylate) is an intermediate-duration, nondepolarizing, skeletal muscle relaxant for intravenous administration. Atracurium besylate is designated as 2,2'-[1,5-pentanediyldis[oxy(3-oxo-3,1-propanediyl)]]bis[1-[(3,4-dimethoxyphenyl)methyl]-1,2,3,4-tetrahydro-6,7-dimethoxy-2-methylisoquinolinium]dibenzenesulfonate. It has a molecular weight of 1243.51, and its molecular formula is  $C_{65}H_{82}N_2O_{18}S_2$ . The structural formula is:



Atracurium besylate is a complex molecule containing four sites at which different stereochemical configurations can occur. The symmetry of the molecule, however, results in only ten, instead of sixteen, possible different isomers. The manufacture of atracurium besylate results in these isomers being produced in unequal amounts but with a consistent ratio. Those molecules in which the methyl group attached to the quaternary nitrogen projects on the opposite side to the adjacent substituted-benzyl moiety predominate by approximately 3:1.

TRACRIUM Injection is a sterile, nonpyrogenic aqueous solution. Each mL contains 10 mg atracurium besylate. The pH is adjusted to 3.25 to 3.65 with benzenesulfonic acid. The multiple-dose vial contains 0.9% benzyl alcohol added as a preservative. TRACRIUM slowly loses potency with time at the rate of approximately 6% per *year* under refrigeration (5°C). TRACRIUM Injection should be refrigerated at 2° to 8°C (36° to 46°F) to preserve potency. Rate of loss in potency increases to approximately 5% per *month* at 25°C (77°F). Upon removal from refrigeration to room temperature storage conditions (25°C/77°F), use TRACRIUM Injection within 14 days even if rerefrigerated.

**CLINICAL PHARMACOLOGY:** TRACRIUM is a nondepolarizing skeletal muscle relaxant. Nondepolarizing agents antagonize the neurotransmitter action of acetylcholine by binding competitively with cholinergic receptor sites on the motor end-plate. This antagonism is inhibited, and neuromuscular block reversed, by acetylcholinesterase inhibitors such as neostigmine, edrophonium, and pyridostigmine.

TRACRIUM can be used most advantageously if muscle twitch response to peripheral nerve stimulation is monitored to assess degree of muscle relaxation.

The duration of neuromuscular block produced by TRACRIUM is approximately one third to one half the duration of block by d-tubocurarine, metocurine, and pancuronium at initially equipotent doses. As with other nondepolarizing neuromuscular blockers, the time to onset of paralysis decreases and the duration of maximum effect increases with increasing doses of TRACRIUM.

The ED<sub>95</sub> (dose required to produce 95% suppression of the muscle twitch response with balanced anesthesia) has averaged 0.23 mg/kg (0.11 to 0.26 mg/kg in various studies). An initial dose of TRACRIUM

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of 0.4 to 0.5 mg/kg generally produces maximum neuromuscular block within 3 to 5 minutes of injection, with good or excellent intubation conditions within 2 to 2.5 minutes in most patients. Recovery from neuromuscular block (under balanced anesthesia) can be expected to begin approximately 20 to 35 minutes after injection. Under balanced anesthesia, recovery to 25% of control is achieved approximately 35 to 45 minutes after injection, and recovery is usually 95% complete approximately 60 to 70 minutes after injection. The neuromuscular blocking action of TRACRIUM is enhanced in the presence of potent inhalation anesthetics. Isoflurane and enflurane increase the potency of TRACRIUM and prolong neuromuscular block by approximately 35%; however, halothane's potentiating effect (approximately 20%) is marginal (see DOSAGE AND ADMINISTRATION).

Repeated administration of maintenance doses of TRACRIUM has no cumulative effect on the duration of neuromuscular block if recovery is allowed to begin prior to repeat dosing. Moreover, the time needed to recover from repeat doses does not change with additional doses. Repeat doses can therefore be administered at relatively regular intervals with predictable results. After an initial dose of 0.4 to 0.5 mg/kg under balanced anesthesia, the first maintenance dose (suggested maintenance dose is 0.08 to 0.10 mg/kg) is generally required within 20 to 45 minutes, and subsequent maintenance doses are usually required at approximately 15- to 25-minute intervals.

Once recovery from the neuromuscular blocking effects of TRACRIUM begins, it proceeds more rapidly than recovery from d-tubocurarine, metocurine, and pancuronium. Regardless of the dose of TRACRIUM, the time from start of recovery (from complete block) to complete (95%) recovery is approximately 30 minutes under balanced anesthesia, and approximately 40 minutes under halothane, enflurane, or isoflurane. Repeated doses have no cumulative effect on recovery rate.

Reversal of neuromuscular block produced by TRACRIUM can be achieved with an anticholinesterase agent such as neostigmine, edrophonium, or pyridostigmine, in conjunction with an anticholinergic agent such as atropine or glycopyrrolate. Under balanced anesthesia, reversal can usually be attempted approximately 20 to 35 minutes after an initial dose of TRACRIUM of 0.4 to 0.5 mg/kg, or approximately 10 to 30 minutes after a 0.08- to 0.10-mg/kg maintenance dose, when recovery of muscle twitch has started. Complete reversal is usually attained within 8 to 10 minutes of the administration of reversing agents. Rare instances of breathing difficulties, possibly related to incomplete reversal, have been reported following attempted pharmacologic antagonism of neuromuscular block induced by TRACRIUM. As with other agents in this class, the tendency for residual neuromuscular block is increased if reversal is attempted at deep levels of block or if inadequate doses of reversal agents are employed.

The pharmacokinetics of TRACRIUM in humans are essentially linear within the 0.3- to 0.6-mg/kg dose range. The elimination half-life is approximately 20 minutes. THE DURATION OF NEUROMUSCULAR BLOCK PRODUCED BY TRACRIUM DOES NOT CORRELATE WITH PLASMA PSEUDACHOLINESTERASE LEVELS AND IS NOT ALTERED BY THE ABSENCE OF RENAL FUNCTION. This is consistent with the results of in vitro studies which have shown that TRACRIUM is inactivated in plasma via two nonoxidative pathways: ester hydrolysis, catalyzed by nonspecific esterases; and Hofmann elimination, a nonenzymatic chemical process which occurs at physiological pH. Some placental transfer occurs in humans.

Radiolabel studies demonstrated that TRACRIUM undergoes extensive degradation in cats, and that neither kidney nor liver plays a major role in its elimination. Biliary and urinary excretion were the major routes of excretion of radioactivity (totaling >90% of the labeled dose within 7 hours of dosing), of which TRACRIUM represented only a minor fraction. The metabolites in bile and urine were similar, including products of Hofmann elimination and ester hydrolysis.

Elderly patients may have slightly altered pharmacokinetic parameters compared to younger patients, with a slightly decreased total plasma clearance which is offset by a corresponding increase in volume of

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distribution. The net effect is that there has been no significant difference in clinical duration and recovery from neuromuscular block observed between elderly and younger patients receiving TRACRIUM.

TRACRIUM is a less potent histamine releaser than d-tubocurarine or metocurine. Histamine release is minimal with initial doses of TRACRIUM up to 0.5 mg/kg, and hemodynamic changes are minimal within the recommended dose range. A moderate histamine release and significant falls in blood pressure have been seen following 0.6 mg/kg of TRACRIUM. The histamine and hemodynamic responses were poorly correlated. The effects were generally short-lived and manageable, but the possibility of substantial histamine release in sensitive individuals or in patients in whom substantial histamine release would be especially hazardous (e.g., patients with significant cardiovascular disease) must be considered.

It is not known whether the prior use of other nondepolarizing neuromuscular blocking agents has any effect on the activity of TRACRIUM. The prior use of succinylcholine decreases by approximately 2 to 3 minutes the time to maximum block induced by TRACRIUM, and may increase the depth of block. TRACRIUM should be administered only after a patient recovers from succinylcholine-induced neuromuscular block.

**INDICATIONS AND USAGE:** TRACRIUM is indicated, as an adjunct to general anesthesia, to facilitate endotracheal intubation and to provide skeletal muscle relaxation during surgery or mechanical ventilation.

**CONTRAINDICATIONS:** TRACRIUM is contraindicated in patients known to have a hypersensitivity to it. Use of TRACRIUM from multiple-dose vials containing benzyl alcohol as a preservative is contraindicated in patients with a known hypersensitivity to benzyl alcohol.

**WARNINGS:** TRACRIUM SHOULD BE USED ONLY BY THOSE SKILLED IN AIRWAY MANAGEMENT AND RESPIRATORY SUPPORT. EQUIPMENT AND PERSONNEL MUST BE IMMEDIATELY AVAILABLE FOR ENDOTRACHEAL INTUBATION AND SUPPORT OF VENTILATION, INCLUDING ADMINISTRATION OF POSITIVE PRESSURE OXYGEN. ADEQUACY OF RESPIRATION MUST BE ASSURED THROUGH ASSISTED OR CONTROLLED VENTILATION. ANTICHOLINESTERASE REVERSAL AGENTS SHOULD BE IMMEDIATELY AVAILABLE.

DO NOT GIVE TRACRIUM BY INTRAMUSCULAR ADMINISTRATION.

TRACRIUM has no known effect on consciousness, pain threshold, or cerebation. It should be used only with adequate anesthesia.

TRACRIUM Injection, which has an acid pH, should not be mixed with alkaline solutions (e.g., barbiturate solutions) in the same syringe or administered simultaneously during intravenous infusion through the same needle. Depending on the resultant pH of such mixtures, TRACRIUM may be inactivated and a free acid may be precipitated.

TRACRIUM Injection 10-mL multiple-dose vials contain benzyl alcohol. In neonates, benzyl alcohol has been associated with an increased incidence of neurological and other complications which are sometimes fatal. TRACRIUM Injection 5-mL single-use vials do not contain benzyl alcohol (see PRECAUTIONS: Pediatric Use).

### PRECAUTIONS:

**General:** Although TRACRIUM is a less potent histamine releaser than d-tubocurarine or metocurine, the possibility of substantial histamine release in sensitive individuals must be considered. Special caution should be exercised in administering TRACRIUM to patients in whom substantial histamine release would be especially hazardous (e.g., patients with clinically significant cardiovascular disease) and in patients with any history (e.g., severe anaphylactoid reactions or asthma) suggesting a greater risk of histamine release.

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In these patients, the recommended initial dose of TRACRIUM is lower (0.3 to 0.4 mg/kg) than for other patients and should be administered slowly or in divided doses over 1 minute.

Since TRACRIUM has no clinically significant effects on heart rate in the recommended dosage range, it will not counteract the bradycardia produced by many anesthetic agents or vagal stimulation. As a result, bradycardia during anesthesia may be more common with TRACRIUM than with other muscle relaxants.

TRACRIUM may have profound effects in patients with myasthenia gravis, Eaton-Lambert syndrome, or other neuromuscular diseases in which potentiation of nondepolarizing agents has been noted. The use of a peripheral nerve stimulator is especially important for assessing neuromuscular block in these patients. Similar precautions should be taken in patients with severe electrolyte disorders or carcinomatosis.

Multiple factors in anesthesia practice are suspected of triggering malignant hyperthermia (MH), a potentially fatal hypermetabolic state of skeletal muscle. Halogenated anesthetic agents and succinylcholine are recognized as the principal pharmacologic triggering agents in MH-susceptible patients; however, since MH can develop in the absence of established triggering agents, the clinician should be prepared to recognize and treat MH in any patient scheduled for general anesthesia. Reports of MH have been rare in cases in which TRACRIUM has been used. In studies of MH-susceptible animals (swine) and in a clinical study of MH-susceptible patients, TRACRIUM did not trigger this syndrome.

Resistance to nondepolarizing neuromuscular blocking agents may develop in burn patients. Increased doses of nondepolarizing muscle relaxants may be required in burn patients and are dependent on the time elapsed since the burn injury and the size of the burn.

The safety of TRACRIUM has not been established in patients with bronchial asthma.

**Long-Term Use in Intensive Care Unit (ICU):** When there is a need for long-term mechanical ventilation, the benefits-to-risk ratio of neuromuscular block must be considered. The long-term (1 to 10 days) infusion of TRACRIUM during mechanical ventilation in the ICU has been evaluated in several studies. Average infusion rates of 11 to 13 mcg/kg per minute (range: 4.5 to 29.5) were required to achieve adequate neuromuscular block. These data suggest that there is wide interpatient variability in dosage requirements. In addition, these studies have shown that dosage requirements may decrease or increase with time. Following discontinuation of infusion of TRACRIUM in these ICU studies, spontaneous recovery of four twitches in a train-of-four occurred in an average of approximately 30 minutes (range: 15 to 75 minutes) and spontaneous recovery to a train-of-four ratio >75% (the ratio of the height of the fourth to the first twitch in a train-of-four) occurred in an average of approximately 60 minutes (range: 32 to 108 minutes).

Little information is available on the plasma levels and clinical consequences of atracurium metabolites that may accumulate during days to weeks of atracurium administration in ICU patients. Laudanosine, a major biologically active metabolite of atracurium without neuromuscular blocking activity, produces transient hypotension and, in higher doses, cerebral excitatory effects (generalized muscle twitching and seizures) when administered to several species of animals. There have been rare spontaneous reports of seizures in ICU patients who have received atracurium or other agents. These patients usually had predisposing causes (such as head trauma, cerebral edema, hypoxic encephalopathy, viral encephalitis, uremia). There are insufficient data to determine whether or not laudanosine contributes to seizures in ICU patients.

WHENEVER THE USE OF TRACRIUM OR ANY NEUROMUSCULAR BLOCKING AGENT IS CONTEMPLATED IN THE ICU, IT IS RECOMMENDED THAT NEUROMUSCULAR TRANSMISSION BE MONITORED CONTINUOUSLY DURING ADMINISTRATION WITH THE HELP OF A NERVE STIMULATOR. ADDITIONAL DOSES OF TRACRIUM OR ANY OTHER NEUROMUSCULAR BLOCKING AGENT SHOULD NOT BE GIVEN BEFORE THERE IS A DEFINITE RESPONSE TO T<sub>1</sub> OR TO THE FIRST TWITCH. IF NO RESPONSE IS ELICITED, INFUSION ADMINISTRATION SHOULD BE DISCONTINUED UNTIL A RESPONSE RETURNS.

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Hemofiltration has a minimal effect on plasma levels of atracurium and its metabolites, including laudanosine. The effects of hemodialysis and hemoperfusion on plasma levels of atracurium and its metabolites are unknown.

**Drug Interactions:** Drugs which may enhance the neuromuscular blocking action of TRACRIUM include: enflurane; isoflurane; halothane; certain antibiotics, especially the aminoglycosides and polymyxins; lithium; magnesium salts; procainamide; and quinidine.

If other muscle relaxants are used during the same procedure, the possibility of a synergistic or antagonist effect should be considered.

The prior administration of succinylcholine does not enhance the duration, but quickens the onset and may increase the depth, of neuromuscular block induced by TRACRIUM. TRACRIUM should not be administered until a patient has recovered from succinylcholine-induced neuromuscular block.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Carcinogenesis and fertility studies have not been performed. Atracurium was evaluated in a battery of three short-term mutagenicity tests. It was nonmutagenic in both the Ames Salmonella assay at concentrations up to 1,000 mcg/plate, and in a rat bone marrow cytogenicity assay at up to paralyzing doses. A positive response was observed in the mouse lymphoma assay under conditions (80 and 100 mcg/mL, in the absence of metabolic activation) which killed over 80% of the treated cells; there was no mutagenicity at 60 mcg/mL and lower, concentrations which killed up to half of the treated cells. A far weaker response was observed in the presence of metabolic activation at concentrations (1,200 mcg/mL and higher) which also killed over 80% of the treated cells.

Mutagenicity testing is intended to simulate chronic (years to lifetime) exposure in an effort to determine potential carcinogenicity. Thus, a single positive mutagenicity response for a drug used infrequently and/or briefly is of questionable clinical relevance.

**Pregnancy: Teratogenic Effects:** Pregnancy Category C. TRACRIUM has been shown to be potentially teratogenic in rabbits when given in doses up to approximately one half the human dose. There are no adequate and well-controlled studies in pregnant women. TRACRIUM should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

TRACRIUM was administered subcutaneously on days 6 through 18 of gestation to nonventilated Dutch rabbits. Treatment groups were given either 0.15 mg/kg once daily or 0.10 mg/kg twice daily. Lethal respiratory distress occurred in two 0.15-mg/kg animals and in one 0.10-mg/kg animal, with transient respiratory distress or other evidence of neuromuscular block occurring in 10 of 19 and in 4 of 20 of the 0.15-mg/kg and 0.10-mg/kg animals, respectively. There was an increased incidence of certain spontaneously occurring visceral and skeletal anomalies or variations in one or both treated groups when compared to nontreated controls. The percentage of male fetuses was lower (41% versus 51%) and the post-implantation losses were increased (15% versus 8%) in the group given 0.15 mg/kg once daily when compared to the controls; the mean numbers of implants (6.5 versus 4.4) and normal live fetuses (5.4 versus 3.8) were greater in this group when compared to the control group.

**Labor and Delivery:** It is not known whether muscle relaxants administered during vaginal delivery have immediate or delayed adverse effects on the fetus or increase the likelihood that resuscitation of the newborn will be necessary. The possibility that forceps delivery will be necessary may increase.

TRACRIUM (0.3 mg/kg) has been administered to 26 pregnant women during delivery by cesarean section. No harmful effects were attributable to TRACRIUM in any of the neonates, although small amounts of TRACRIUM were shown to cross the placental barrier. The possibility of respiratory depression in the neonate should always be considered following cesarean section during which a neuromuscular blocking agent has been administered. In patients receiving magnesium sulfate, the reversal of neuromuscular block may be unsatisfactory and the dose of TRACRIUM should be lowered as indicated.

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**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when TRACRIUM is administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness in pediatric patients below the age of 1 month have not been established.

**Use in the Elderly:** Since marketing in 1983, uncontrolled clinical experience and limited data from controlled trials have not identified differences in effectiveness, safety, or dosage requirements between healthy elderly and younger patients (see CLINICAL PHARMACOLOGY); however, as with other neuromuscular blocking agents, the use of a peripheral nerve stimulator to monitor neuromuscular function is suggested (see DOSAGE AND ADMINISTRATION).

### **ADVERSE REACTIONS:**

**Observed in Controlled Clinical Studies:** TRACRIUM was well tolerated and produced few adverse reactions during extensive clinical trials. Most adverse reactions were suggestive of histamine release. In studies including 875 patients, TRACRIUM was discontinued in only one patient (who required treatment for bronchial secretions), and six other patients required treatment for adverse reactions attributable to TRACRIUM (wheezing in one, hypotension in five). Of the five patients who required treatment for hypotension, three had a history of significant cardiovascular disease. The overall incidence rate for clinically important adverse reactions, therefore, was 7/875 or 0.8%. Table 1 includes all adverse reactions reported attributable to TRACRIUM during clinical trials with 875 patients.

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**Table 1: Percent of Patients Reporting Adverse Reactions**

Adverse Reaction	Initial Dose of TRACRIUM (mg/kg)			Total (n = 875)
	0.00-0.30 (n = 485)	0.31-0.50* (n = 366)	≥0.60 (n = 24)	
Skin Flush	1.0%	8.7%	29.2%	5.0%
Erythema	0.6%	0.5%	0%	0.6%
Itching	0.4%	0%	0%	0.2%
Wheezing/Bronchial Secretions	0.2%	0.3%	0%	0.2%
Hives	0.2%	0%	0%	0.1%

\* Includes the recommended initial dosage range for most patients.

Most adverse reactions were of little clinical significance unless they were associated with significant hemodynamic changes. Table 2 summarizes the incidences of substantial vital sign changes noted during clinical trials of TRACRIUM with 530 patients, without cardiovascular disease, in whom these parameters were assessed.

**Table 2: Percent of Patients Showing >30% Vital Sign Changes Following Administration of TRACRIUM**

Vital Sign Change	Initial Dose of TRACRIUM (mg/kg)			Total (n = 530)
	0.00-0.30 (n = 365)	0.31-0.50* (n = 144)	≥0.60 (n = 21)	
Mean Arterial Pressure				
Increase	1.9%	2.8%	0%	2.1%
Decrease	1.1%	2.1%	14.3%	1.9%
Heart Rate				
Increase	1.6%	2.8%	4.8%	2.1%
Decrease	0.8%	0%	0%	0.6%

\* Includes the recommended initial dosage range for most patients.

**Observed in Clinical Practice:** Based on initial clinical practice experience in approximately 3 million patients who received TRACRIUM in the US and in the United Kingdom, spontaneously reported adverse reactions were uncommon (approximately 0.01% to 0.02%). The following adverse reactions are among the most frequently reported, but there are insufficient data to support an estimate of their incidence:

**General:** Allergic reactions (anaphylactic or anaphylactoid responses) which, in rare instances, were severe (e.g., cardiac arrest).

**Musculoskeletal:** Inadequate block, prolonged block.

**Cardiovascular:** Hypotension, vasodilatation (flushing), tachycardia, bradycardia.

**Respiratory:** Dyspnea, bronchospasm, laryngospasm.

**Integumentary:** Rash, urticaria, reaction at injection site.

There have been rare spontaneous reports of seizures in ICU patients following long-term infusion of atracurium to support mechanical ventilation. There are insufficient data to define the contribution, if any, of atracurium and/or its metabolite laudanosine. (See PRECAUTIONS: Long-Term Use in Intensive Care Unit [ICU]).

**OVERDOSAGE:** There has been limited experience with overdosage of TRACRIUM. The possibility of iatrogenic overdosage can be minimized by carefully monitoring muscle twitch response to peripheral nerve



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stimulation. Excessive doses of TRACRIUM can be expected to produce enhanced pharmacological effects. Overdosage may increase the risk of histamine release and cardiovascular effects, especially hypotension. If cardiovascular support is necessary, this should include proper positioning, fluid administration, and the use of vasopressor agents if necessary. The patient's airway should be assured, with manual or mechanical ventilation maintained as necessary. A longer duration of neuromuscular block may result from overdosage and a peripheral nerve stimulator should be used to monitor recovery. Recovery may be facilitated by administration of an anticholinesterase reversing agent such as neostigmine, edrophonium, or pyridostigmine, in conjunction with an anticholinergic agent such as atropine or glycopyrrolate. The appropriate package inserts should be consulted for prescribing information.

Three pediatric patients (3 weeks, 4 and 5 months of age) unintentionally received doses of 0.8 mg/kg to 1.0 mg/kg of TRACRIUM. The time to 25% recovery (50 to 55 minutes) following these doses, which were 5 to 6 times the ED<sub>95</sub> dose, was moderately longer than the corresponding time observed following doses 2.0 to 2.5 times the TRACRIUM ED<sub>95</sub> dose in infants (22 to 36 minutes). Cardiovascular changes were minimal. Nonetheless the possibility of cardiovascular changes must be considered in the case of overdose.

An adult patient (17 years of age) unintentionally received an initial dose of 1.3 mg/kg of TRACRIUM. The time from injection to 25% recovery (83 minutes) was approximately twice that observed following maximum recommended doses in adults (35 to 45 minutes). The patient experienced moderate hemodynamic changes (13% increase in mean arterial pressure and 27% increase in heart rate) which persisted for 40 minutes and did not require treatment.

The intravenous LD<sub>50</sub>s determined in nonventilated male and female albino mice and male Wistar rats were 1.9, 2.01, and 1.31 mg/kg, respectively. Deaths occurred within 2 minutes and were caused by respiratory paralysis. The subcutaneous LD<sub>50</sub> determined in nonventilated male Wistar rats was 282.8 mg/kg. Tremors, ptosis, loss of reflexes, and respiratory failure preceded death which occurred 45 to 120 minutes after injection.

**DOSAGE AND ADMINISTRATION:** To avoid distress to the patient, TRACRIUM should not be administered before unconsciousness has been induced. TRACRIUM should not be mixed in the same syringe, or administered simultaneously through the same needle, with alkaline solutions (e.g., barbiturate solutions).

TRACRIUM should be administered intravenously. **DO NOT GIVE TRACRIUM BY INTRAMUSCULAR ADMINISTRATION.** Intramuscular administration of TRACRIUM may result in tissue irritation and there are no clinical data to support this route of administration.

As with other neuromuscular blocking agents, the use of a peripheral nerve stimulator will permit the most advantageous use of TRACRIUM, minimizing the possibility of overdosage or underdosage, and assist in the evaluation of recovery.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

**Bolus Doses for Intubation and Maintenance of Neuromuscular Block: Adults:** A dose of TRACRIUM of 0.4 to 0.5 mg/kg (1.7 to 2.2 times the ED<sub>95</sub>), given as an intravenous bolus injection, is the recommended initial dose for most patients. With this dose, good or excellent conditions for nonemergency intubation can be expected in 2 to 2.5 minutes in most patients, with maximum neuromuscular block achieved approximately 3 to 5 minutes after injection. Clinically required neuromuscular block generally lasts 20 to 35 minutes under balanced anesthesia. Under balanced anesthesia, recovery to 25% of control is achieved approximately 35 to 45 minutes after injection, and recovery is usually 95% complete approximately 60 minutes after injection.

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TRACRIUM is potentiated by isoflurane or enflurane anesthesia. The same initial dose of TRACRIUM of 0.4 to 0.5 mg/kg may be used for intubation prior to administration of these inhalation agents; however, if TRACRIUM is first administered under steady state of isoflurane or enflurane, the initial dose of TRACRIUM should be reduced by approximately one third, i.e., to 0.25 to 0.35 mg/kg, to adjust for the potentiating effects of these anesthetic agents. With halothane, which has only a marginal (approximately 20%) potentiating effect on TRACRIUM, smaller dosage reductions may be considered.

Doses of TRACRIUM of 0.08 to 0.10 mg/kg are recommended for maintenance of neuromuscular block during prolonged surgical procedures. The first maintenance dose will generally be required 20 to 45 minutes after the initial injection of TRACRIUM, but the need for maintenance doses should be determined by clinical criteria. Because TRACRIUM lacks cumulative effects, maintenance doses may be administered at relatively regular intervals for each patient, ranging approximately from 15 to 25 minutes under balanced anesthesia, slightly longer under isoflurane or enflurane. Higher doses of TRACRIUM (up to 0.2 mg/kg) permit maintenance dosing at longer intervals.

**Pediatric Patients:** No dosage adjustments of TRACRIUM are required for pediatric patients 2 years of age or older. A dose of TRACRIUM of 0.3 to 0.4 mg/kg is recommended as the initial dose for infants (1 month to 2 years of age) under halothane anesthesia. Maintenance doses may be required with slightly greater frequency in infants and children than in adults.

**Special Considerations:** An initial dose of TRACRIUM of 0.3 to 0.4 mg/kg, given slowly or in divided doses over 1 minute, is recommended for adults, adolescents, children, or infants with significant cardiovascular disease and for adults, adolescents, children, or infants with any history (e.g., severe anaphylactoid reactions or asthma) suggesting a greater risk of histamine release.

Dosage reductions must be considered also in patients with neuromuscular disease, severe electrolyte disorders, or carcinomatosis in which potentiation of neuromuscular block or difficulties with reversal have been demonstrated. There has been no clinical experience with TRACRIUM in these patients, and no specific dosage adjustments can be recommended. No dosage adjustments of TRACRIUM are required for patients with renal disease.

An initial dose of TRACRIUM of 0.3 to 0.4 mg/kg is recommended for adults following the use of succinylcholine for intubation under balanced anesthesia. Further reductions may be desirable with the use of potent inhalation anesthetics. The patient should be permitted to recover from the effects of succinylcholine prior to administration of TRACRIUM. Insufficient data are available for recommendation of a specific initial dose of TRACRIUM for administration following the use of succinylcholine in children and infants.

**Use by Continuous Infusion: Infusion in the Operating Room (OR):** After administration of a recommended initial bolus dose of TRACRIUM (0.3 to 0.5 mg/kg), a diluted solution of TRACRIUM can be administered by continuous infusion to adults and pediatric patients aged 2 or more years for maintenance of neuromuscular block during extended surgical procedures.

Infusion of TRACRIUM should be individualized for each patient. The rate of administration should be adjusted according to the patient's response as determined by peripheral nerve stimulation. Accurate dosing is best achieved using a precision infusion device.

Infusion of TRACRIUM should be initiated only after early evidence of spontaneous recovery from the bolus dose. An initial infusion rate of 9 to 10 mcg/kg per minute may be required to rapidly counteract the spontaneous recovery of neuromuscular function. Thereafter, a rate of 5 to 9 mcg/kg per minute should be adequate to maintain continuous neuromuscular block in the range of 89% to 99% in most pediatric and adult patients under balanced anesthesia. Occasional patients may require infusion rates as low as 2 mcg/kg per minute or as high as 15 mcg/kg per minute.

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The neuromuscular blocking effect of TRACRIUM administered by infusion is potentiated by enflurane or isoflurane and, to a lesser extent, by halothane. Reduction in the infusion rate of TRACRIUM should, therefore, be considered for patients receiving inhalation anesthesia. The infusion rate of TRACRIUM should be reduced by approximately one third in the presence of steady-state enflurane or isoflurane anesthesia; smaller reductions should be considered in the presence of halothane.

In patients undergoing cardiopulmonary bypass with induced hypothermia, the rate of infusion of TRACRIUM required to maintain adequate surgical relaxation during hypothermia (25° to 28°C) has been shown to be approximately half the rate required during normothermia.

Spontaneous recovery from neuromuscular block following discontinuation of infusion of TRACRIUM may be expected to proceed at a rate comparable to that following administration of a single bolus dose.

**Infusion in the Intensive Care Unit (ICU):** The principles for infusion of TRACRIUM in the OR are also applicable to use in the ICU.

An infusion rate of 11 to 13 mcg/kg per minute (range: 4.5 to 29.5) should provide adequate neuromuscular block in adult patients in an ICU. Limited information suggests that infusion rates required for pediatric patients in the ICU may be higher than in adult patients. There may be wide interpatient variability in dosage requirements and these requirements may increase or decrease with time (see PRECAUTIONS: Long-Term Use in Intensive Care Unit [ICU]). Following recovery from neuromuscular block, readministration of a bolus dose may be necessary to quickly re-establish neuromuscular block prior to reinstitution of the infusion.

**Infusion Rate Tables:** The amount of infusion solution required per minute will depend upon the concentration of TRACRIUM in the infusion solution, the desired dose of TRACRIUM, and the patient's weight. The following tables provide guidelines for delivery, in mL/hr (equivalent to microdrops/min when 60 microdrops = 1 mL), of solutions of TRACRIUM in concentrations of 0.2 mg/mL (20 mg in 100 mL) or 0.5 mg/mL (50 mg in 100 mL) with an infusion pump or a gravity flow device.

**Table 3: Infusion Rates of TRACRIUM for a  
Concentration of 0.2 mg/mL**

Patient Weight (kg)	Drug Delivery Rate (mcg/kg per minute)								
	5	6	7	8	9	10	11	12	13
	Infusion Delivery Rate (mL/hr)								
30	45	54	63	72	81	90	99	108	117
35	53	63	74	84	95	105	116	126	137
40	60	72	84	96	108	120	132	144	156
45	68	81	95	108	122	135	149	162	176
50	75	90	105	120	135	150	165	180	195
55	83	99	116	132	149	165	182	198	215
60	90	108	126	144	162	180	198	216	234
65	98	117	137	156	176	195	215	234	254
70	105	126	147	168	189	210	231	252	273
75	113	135	158	180	203	225	248	270	293
80	120	144	168	192	216	240	264	288	312
90	135	162	189	216	243	270	297	324	351
100	150	180	210	240	270	300	330	360	390

## TRACRIUM® (atracurium besylate) Injection

**Table 4: Infusion Rates of TRACRIUM for a  
Concentration of 0.5 mg/mL**

Patient Weight (kg)	Drug Delivery Rate (mcg/kg per minute)								
	5	6	7	8	9	10	11	12	13
	Infusion Delivery Rate (mL/hr)								
30	18	22	25	29	32	36	40	43	47
35	21	25	29	34	38	42	46	50	55
40	24	29	34	38	43	48	53	58	62
45	27	32	38	43	49	54	59	65	70
50	30	36	42	48	54	60	66	72	78
55	33	40	46	53	59	66	73	79	86
60	36	43	50	58	65	72	79	86	94
65	39	47	55	62	70	78	86	94	101
70	42	50	59	67	76	84	92	101	109
75	45	54	63	72	81	90	99	108	117
80	48	58	67	77	86	96	106	115	125
90	54	65	76	86	97	108	119	130	140
100	60	72	84	96	108	120	132	144	156

**Compatibility and Admixtures:** Infusion solutions of TRACRIUM may be prepared by admixing TRACRIUM Injection with an appropriate diluent such as 5% Dextrose Injection, USP; 0.9% Sodium Chloride Injection, USP; or 5% Dextrose and 0.9% Sodium Chloride Injection, USP. Infusion solutions should be used within 24 hours of preparation. Unused solutions should be discarded. Solutions containing 0.2 mg/mL or 0.5 mg/mL TRACRIUM in the above diluents may be stored either under refrigeration or at room temperature for 24 hours without significant loss of potency. Care should be taken during admixture to prevent inadvertent contamination. Visually inspect prior to administration.

Spontaneous degradation of TRACRIUM has been demonstrated to occur more rapidly in Lactated Ringer's solution than in 0.9% sodium chloride solution. Therefore, it is recommended that Lactated Ringer's Injection, USP not be used as a diluent in preparing solutions of TRACRIUM for infusion.

**HOW SUPPLIED:** TRACRIUM Injection, 10 mg atracurium besylate in each mL.  
5-mL Single-Use Vial (50 mg atracurium besylate per vial). Tray of 10 (NDC 0173-0940-44).  
10-mL Multiple-Dose Vial (100 mg atracurium besylate per vial). Contains benzyl alcohol (see WARNINGS).  
Tray of 10 (NDC 0173-0545-00).

**STORAGE:** TRACRIUM Injection should be refrigerated at 2° to 8°C (36° to 46°F) to preserve potency. DO NOT FREEZE. Upon removal from refrigeration to room temperature storage conditions (25°C/77°F), use TRACRIUM Injection within 14 days even if rerefrigerated.

**GlaxoWellcome**

Manufactured by  
Catalytica Pharmaceuticals, Inc.  
Greenville, NC 27834

**TRACRIUM® (atracurium besylate) Injection**

for  
Glaxo Wellcome Inc.  
Research Triangle Park, NC 27709

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November 1997

RL-495

10 Single-Use Vials

5 mL each

**TRACURIUM® Injection**  
(atracurium besylate)

**50 mg/5 mL (10 mg/mL)**

**REFRIGERATE:** Store at 2° to 8°C (36° to 46°F). DO NOT FREEZE.

**GlaxoWellcome**

Glaxo Wellcome Inc.  
Research Triangle Park, NC 27709

Made in U.S.A.

10 Single-Use Vials  
5 mL each  
**TRACURIUM® Injection**  
(atracurium besylate)  
**50 mg/5 mL (10 mg/mL)**

A sterile, non-pyrogenic solution for intravenous injection. The vehicle contains benzenesulfonic acid (added to adjust pH) and Water for Injection.  
**REFRIGERATE:** Store at 2° to 8°C (36° to 46°F). DO NOT FREEZE.

10 Single-Use Vials 5 mL each  
**TRACURIUM® Injection**  
(atracurium besylate)

**50** mg/5 mL (10 mg/mL)

NDC 0173-0940-44

A sterile, non-pyrogenic solution for intravenous injection. The vehicle contains benzenesulfonic acid (added to adjust pH) and Water for Injection.

**WARNING: Paralyzing Agent. Causes Respiratory Arrest.** Facilities must be immediately available for artificial respiration. For indications, dosage, precautions, etc., see enclosed package insert.

**REFRIGERATE:** Store at 2° to 8°C (36° to 46°F). DO NOT FREEZE.

**CAUTION:** Federal law prohibits dispensing without prescription.

FOR LOT NO. AND EXPIRATION DATE – SEE OTHER SIDE

NSN 6505-01-318-1566



627273  
Rev. 7/97

Made in U.S.A.

Research Triangle Park, NC 27709

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**REFRIGERATE:** Store at 2° to 8°C (36° to 46°F). DO NOT FREEZE.

**TRACURIUM® Injection**  
(atracurium besylate)  
**50 mg/5 mL (10 mg/mL)**

5 mL each

10 Single-Use Vials